Section X

SUMMARY OF RECOMMENDATIONS: STRATEGIC PLANS FOR THE FUTURE

The staff of the Health Care Safety Net Administration (HCSNA) spent the past year assessing contract compliance, identifying issues, assisting in work plan development, and monitoring implementation of various plans that will create a successful health care delivery system.

Recommendations are provided within each of the following nine categories:

1. HCSNA Program Management
2. Alliance Program Administration
3. Quality of Care and Integrated Health Care System
4. Access to Care
5. Utilization of Services
6. Performance Improvement
7. Medical Homes
8. Financial Performance
9. Member and Provider Satisfaction

The entity responsible for implementation of each recommendation is listed along with a timeframe for completion. Each section will end with a general conclusion statement and will list major barrier(s) that will impede implementation of the recommendation.

Overall Program Management and Administration Recommendations

The HCSNA is charged with monitoring and oversight of the GSCHC Contract. The HCSNA strategic plan lays out goals and objectives that create an infrastructure for carrying out the responsibilities of monitoring and oversight. The recommendations in this section are critical for the successful operation of the overall program as well.

The administrative functions of the Alliance have been reviewed by the HCSNA during the Administrative Services Review. The following recommendations for improvement of management functions will be implemented by the HCSNA in contract years 2 and 3.

HCSNA Program Management

1. Construct a performance-based contract. This recommendation calls for implementing contractual requirements with outcome targets identified for the vendor to achieve as an incentive to performance. Failure to reach the contractual goal or target will result in a diminished payment or withhold from the overall reimbursement.
2. Eliminate the presumptive eligibility process for inpatient only and monitor ongoing cost to determine future actions.
3. Implement a single point of entry process for application submission and eligibility determination.
4. Develop and implement a retroactive payment process.
5. Develop and implement a healthcare reimbursement recovery program. This recommendation contemplates payment recovery of those health care services that were paid incorrectly or erroneously. They include:

   - Subrogation
   - Right of recovery
   - Overpayment
   - Eligibility error
   - Payment duplication
   - Provider billing audits

   These types of recovery services can be implemented by a third party and/or performed by vendor or HCSNA staff. All or a prioritized selection of these

services are commonly used by health plans, third-party administrators, government programs, self-insured corporations, commercial insurance carriers and HMOs to control costs and prevent overpayment for services. Implementing this type of program, or several of the key elements, in the DC Alliance is in alignment with existing contract terms, but may require additional contractual and benefit coverage language.

6. HCSNA needs rule-making authority that will enable us to create and amend regulations that govern the program. The HCSNA would not need approval of the contractor to make necessary program changes.
7. The HCSNA needs budget authority to increase the program staff to meet the demands of the program. The total number of staff needed to monitor the contract is 25.
8. Acquire immediate office space for 9 new staff, and 4 additional staff the next year.
9. Cross-train staff to function in more than one job.

Alliance Program Administration (changes to be implemented by vendor)

1. Include the Department of Corrections members in the eligibility file and track the Metropolitan Police Department claims by type of enrollee.
2. Revise the stored electronic enrollment and eligibility data fields. This would include adding the pertinent fields from the application to the electronic file to track member employment, disability, race, etc.
3. Implement a Single Point of Entry process for application submission and eligibility determination. In addition to a single point of entry for the Alliance or another program's coverage, the Alliance will provide strict guidelines for enrollment processes including document verification, program screening, and management of the exceptions populations: Department of Corrections enrollees and Metropolitan Police Department enrollees.
4. Provide access and training to the ACEDS System.
5. Implement real-time electronic eligibility access for providers.
6. Implement electronic data interchange for claims submission by providers and develop and implement an integrated information system. This system will allow for an enterprise-wide Master Patient Index that allows all Alliance members medical records to be accessed by any provider at any point in the system. It will also allow for centralized scheduling and, eventually, an electronic provider order entry and electronic medical records to further advance the patient-centered model of care adopted by the Alliance.
7. Develop a working definition for medical homes.

Quality of Care and Integrated Health Care System

Quality of Care will continue to be a prominent focus of the activities planned for Year 2 of the Alliance program with the greater focus on successful outcomes. The key recommendations for the second year are as follows:

- Secure vendor to conduct chart audits of Alliance quality of care.
- Work with the Alliance to improve quality and accuracy of claims coding and reporting, thereby improving the accuracy of quality monitoring reports.
- Continue emergency department quality improvement initiative focusing on improving ED wait times, improving follow-up care, and enhancing patient-flow processes.
- Increase the rate of primary care and preventive care visits through the appropriate utilization of the medical home, while simultaneously decreasing inappropriate utilization of the ER and the hospital.

- Obtain valid results for all core performance indicators for quality including those that are dependent on medical record reviews to create a Year 1 baseline for quality.
- Implement focused initiatives to improve quality in targeted areas such as improved preventive screening rates for breast cancer and cervical cancer.
- Improve the coordination of care and informational transfer across different Alliance care delivery sites, i.e., between ER and the primary care clinics, and between the clinics and the hospital.
- Evaluate and continue to enhance current disease management strategies for quality and effectiveness and work with the Alliance to enhance utilization and effectiveness of these programs.
- Evaluate quality of hospital-based care through a defined set of indicators and through medical chart audits.
- Expand the focus of quality monitoring and improvement efforts beyond the primary Alliance partners to other contracted hospitals and clinics within the system.
- Conduct clinical studies describing the quality of care rendered to the population.
- Ensure that monthly onsite audits are performed.
- Ensure that there are monthly provider surveys performed for accurate documentation of the positive and negative aspects of being a provider.
- Link the data reports to quality issues as much as possible (i.e., pharmacy reports to medications or disease categories).
- Continue the Quality of Care and ED Automation Meetings and encourage increased participation of members to voice more recommendations.
- Continue to reinforce the perspective of contractors as not only monitors of the contract but as resource personnel.
- Review and consolidate data reports submitted to the HCSNA.

Access to Care

- Implement the community systems assessment review.
- Continue monitoring the provider network through monthly reports and biannual geo-access mapping.
- Implement targeted initiatives to improve access to certain specialty provider categories such as dentistry.
- Ensure the implementation of a coordinated and collaborative system for appointment scheduling and tracking both for primary care, specialty care, and follow-up appointments post-discharge from the hospital or the ER.
- Develop a system for evaluating appointment wait times particularly for primary care and dental care services.
- Periodic retraining of the providers by Chartered to ensure they are knowledgeable of the eligibility requirements and process.

Utilization of Services

Who is Using Services?

- Continue to monitor utilization rate by overall use, by gender, age, and ward.
- Provide results to the Alliance to promote utilization by age and location.

We expect to see greater utilization of services by the eligible population as the Alliance program matures, members settle into their medical homes, and the number of presumptive eligible members stabilizes.

Who is Providing Services?

- Continue to monitor the distribution of members cared for by each Alliance vendor.
- Determine the ratio of patients to individual providers and track this measure.
- Determine the number of distinct members that received primary care and the referrals made for specialty care and monitor this trend.
- Assess the treatment frequency based on age group and disease condition for

treatment planning and disease management.
- Profile frequent disease conditions to benchmark, implement best practices and access cost efficiency of vendor providers.
- Assist new members to select PCPs within the network that have the lowest patient to provider ratio.

What Services Are Being Provided?

Physician Services

- Continue to monitor physician services by category of services and by medical home.
- Continue to monitor the ratio of the number of providers to cost per service claim type.
- Provide a focused study to determine the number of patients each PCP actually serves, and the number of referrals received by each member.
- Provide a focused study to determine the number of patients each clinic actually cares for, the number of physicians allocated to provide care, the number of referrals and coordinated care, and the number of referrals received by each member.
- Review inpatient services provided, and evaluate by case-mixed adjustment.
- Profile members with selected critical disease conditions by service category and medical home.

Inpatient Services (IP)

While IP healthcare claims make up less than 2 percent of the overall number of paid claims for the first year of operation, their total dollar value is nearly one-half of the overall payment for annual services. Recommendations are:

- Incorporate all provider claims, including services provided to the DOC members, in the claims database for accurate benchmarking.
- Identify the high cost IP disease conditions for the first year; target the management goals and provide technical assistance for appropriate interventions.
- Continue to monitor ALOS, identify by provider, and analyze by a severity of illness scale.

Emergency Department

The following recommendations will aid the HCSNA to improve oversight and comparative analysis for the second year of operations and beyond:

- Continue to monitor performance measures for comparison to other national and regional benchmarks.
- Establish thresholds and goals for the performance indicators, including frequency distribution for overall claims payment.
- Continue to seek appropriate benchmarks for level-of-service comparison.
- Incorporate all provider claims, including OTSP and services provided to the DOC members, in the claims database for accurate benchmarking.

Dental Services

- Continue to monitor screening and preventative services and the overall extraction service rates provided to Alliance members.
- Establish thresholds and goals for these performance indicators based on the above results.
- Continue to monitor access to dental care and account for changes by comparison to the baseline service frequency distribution and national/regional benchmarks.

Pharmacy Services

- Extend weekday hours and weekend pharmacy access, increase the total number of Alliance pharmacies, and assess customer satisfaction through direct surveys.

Performance Improvement

Based on the initial baseline results, the following are the areas where the HCSNA and the Alliance will need to focus its performance improvement efforts in the future:

- Identify and implement strategies for improving access to services in certain specialty provider categories such as dentistry.
- Continue to decrease Emergency Department wait times through enhanced patient flow process and improved follow-up care.
- Increase the rate of primary care and preventive care visits through the appropriate use of the medical home, simultaneously decreasing inappropriate use of the ER and the hospital.
- Increase preventive screenings such as mammography rates, cholesterol screening for patients with evidence of cardiac disease, and HbA1c tests in diabetics.
- Improve patient satisfaction with care provided through the Alliance particularly in areas such as timeliness and convenience of care services in the primary care setting.
- Continue to enhance the process of data collection and reporting with a focus on indicators of health outcomes.
- Establish thresholds and goals for each of the performance indicators based upon baseline results and national/regional benchmarks.

Medical Homes

- Expand the current member satisfaction surveys to include medical home queries.
- Continue to educate Alliance members regarding their medical home and the services available.
- Define the medical home model for use with the Alliance population.
- Create the organizational infrastructure required to support medical home use in the community.
- Determine services that will be provided by the medical home and serve as the basis for the coordination of primary care.
- Develop a plan for implementing the infrastructure to assess and coordinate services within each medical home and the surrounding community.
- Continue to educate providers on their role as a medical home provider and the range of support services available through the Alliance.
- Empower medical home providers to perform prior authorization to better manage the delivery of care through appropriate referrals and service.
- Implement an expanded performance measurement system along with appropriate benchmarks and quality strategies.
- Continue to measure medical home use by Alliance members; group and measure the coordination and performance of services by diagnosis and medical home; spot check the availability of PCPs including their capacity to care for new members; and perform random medical record reviews to substantiate findings.

Financial Performance

- Analyze the rate structure (compare with Medicaid managed care rates and provider individual rates for Medicaid).
- Conduct monthly financial reviews that lead to 6-month and annual reconciliation.

Contractor Operational Performance

- Ensure that staff is competent to perform care to the population at the level of expertise required.
- Ensure that staff follows the policies and procedures of the facility in which they are employed to include good standards of care.
- GSCH, Chartered, and Unity work with the Alliance office to develop a cohesive set of approved policies governing the operation of the Alliance.
- The Alliance office submits requested reports in a timely manner.

Alliance Member/Provider Satisfaction

The Contractor should follow the guidelines and recommendations of the Committee as outlined below:

- Develop Provider Satisfaction Component.
- Ensure corrections to customer service and provider satisfaction reporting systems.
- Ensure efficient documentation of all complaints, issues, praises, etc.
- Ensure that all complaints are documented and tracked for timely resolution.

Goals for the Future

- Resolve the status of the DC General campus.
- Make the HCSNA the most efficient, cost-effective department in the DOH.